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| A 000 | INITIAL COMMENTS<br><br>This visit was for a recertification of a hospital.<br><br>Dates of survey: 12/7/2015 to 12/9/2015<br><br>Facility number: 005184<br><br>QA: cjl 12/22/15 | A 000 | | |
| A 043 | 482.12 GOVERNING BODY<br><br>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...<br><br>This CONDITION is not met as evidenced by:<br>Based on document review and staff interview, it was determined that the Governing Body failed to ensure written Medical Staff bylaws and Medical Staff Rules and Regulations for effectively carrying out its responsibilities for the conduct of the hospital. The facility failed to ensure which categories of practitioners are eligible candidates for appointment to the medical staff for the hospital (see A 045); failed to appoint members to the medical staff (see A 046); failed to ensure the Medical Staff have bylaws (see A 047); failed to approve medical staff bylaws and other medical staff rules and regulations (see A 048); failed to approve written Medical Staff bylaws that describe the privileging process to be used by the hospital (see A 050) and failed to have written criteria for appointment to the medical staff and granting of medical staff privileges that are not | A 043 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| A 043 | Continued From page 1<br>dependent solely upon certification, fellowship, or membership in a specialty body or society (see A 051).<br><br>The cumulative effect of these systematic problems resulted in the hospital's inability to ensure an effective Governing Body that is legally responsible for the conduct of the hospital. | A 043 | | |
| A 045 | 482.12(a)(1) MEDICAL STAFF<br><br>[The governing body must] determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the Governing Body failed to ensure which categories of practitioners are eligible candidates for appointment to the medical staff for the hospital.<br><br>Findings include:<br><br>1. The facility lacked documentation that the Governing Body had required the Medical Staff to have medical staff bylaws that addressed the categories of practitioners that are eligible for appointment to the medical staff.<br><br>2. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Governing Board failed to ensure the Medical Staff have bylaws to define categories of practitioners that are eligible candidates for appointment to the medical staff. The Medical Staff does not have medical staff bylaws. | A 045 | | |
| A 046 | 482.12(a)(2) MEDICAL STAFF - | A 046 | | |

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| A 046 | Continued From page 2<br>APPOINTMENTS<br><br>[The governing body must] appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the Governing Body failed to appoint members to the medical staff.<br><br>Findings include:<br><br>1. The Govorning Board meeting minutes were reviewed for the previous 12 months and lacked documentation of the recommendations of appointment from the existing medical staff.<br><br>2. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff are not appointed by the Governing Board. The Medical Staff does not have medical staff bylaws. | A 046 | | |
| A 047 | 482.12(a)(3) MEDICAL STAFF - BYLAWS<br><br>[The governing body must] assure that the medical staff has bylaws.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the Governing Body failed to ensure the Medical Staff has bylaws.<br><br>Findings include:<br><br>In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff does not have bylaws. | A 047 | | |

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| A 048 | 482.12(a)(4) MEDICAL STAFF - BYLAWS AND RULES<br><br>[The governing body must] approve medical staff bylaws and other medical staff rules and regulations.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the governing body failed to approve and adopt medical staff bylaws and medical staff rules and regulations<br><br>Findings include:<br><br>In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the governing body has not adopted medical staff bylaws and medical staff rules and regulations. | A 048 | | |
| A 050 | 482.12(a)(6) MEDICAL STAFF - SELECTION CRITERIA<br><br>[The governing body must] ensure that criteria for selection are individual character, competence, training, experience, and judgement.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the Governing Body failed to approve written Medical Staff bylaws that ensure that criteria for appointment to the Medical Staff address individual character, competence, training, experience and judgement for 12 of 12 psychiatrists on the on call medical staff schedule and 5 of 5 Nurse Practitioners.<br><br>Findings include:<br><br>1. The 2014 Governing Board bylaws and 2014 Governing Board minutes lacked documentation of written Medical Staff bylaws or Medical Staff | A 050 | | |

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| A 050 | Continued From page 4<br>Rules and Regulations that describe the criteria for selection to the medical staff to include individual character, competence, training, experience, and judgement for 12 Medical Staff and 5 Nurse Practitioners.<br><br>2. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff the Nurse Practitioners are not appointed by the Governing Board and the Medical Staff does not have medical staff bylaws that address individual character, competence, training, experience and judgement for each practitioner. | A 050 | | |
| A 051 | 482.12(a)(7) MEDICAL STAFF - PRIVILEGES ON STAFF<br><br>[The governing body must] ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the Governing Board failed to ensure the Medical Staff have medical staff bylaws that ensure medical staff membership was not dependent solely upon certification, fellowship or membership in a specialty body or society.<br><br>Findings include:<br><br>1. The 2014 Governing Board bylaws lack approval of written Medical Staff bylaws or Medical Staff Rules and Regulations that described staff privileges which are not | A 051 | | |

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| A 051 | Continued From page 5<br>dependent solely upon certification, fellowship, or membership in a specialty body or society.<br><br>2. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff are not appointed by the Governing Board and the Medical Staff does not have medical staff bylaws. | A 051 | | |
| A 164 | 482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to ensure less restrictive interventions were attempted prior to restraint and seclusion for 1 of 4 (N5) closed patient medical records reviewed for patients in restraint/seclusion.<br><br>Findings:<br><br>1. Review of policy titled, Restraint Inpatient Unit - Procedure, revised/reapproved 4/13/15, indicated on pg. 5 under documentation section, each episode of restraint should include the consideration or failure of non-physical intervention.<br><br>2. Review of closed patient medical records confirmed patient N5 was placed in 4-way leather restraints on 8/18/15 at 1625 hours and the medical record lacked documentation of interventions attempted. | A 164 | | |

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| A 164 | Continued From page 6<br><br>3. In interview, on 12/7/15 at approximately 1410 hours, staff #21 (Supervisor of Medical Records) confirmed the Restraint/Seclusion Flow Sheet for patient N5 lacked documentation of interventions attempted prior to restraint/seclusion as required by facility policy and procedure. | A 164 | | |
| A 166 | 482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>The use of restraint or seclusion must be--<br>(i) in accordance with a written modification to the patient's plan of care.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to ensure the treatment plan was modified after the use of restraint/seclusion for 4 of 4 (N1, N3, N4 and N5) closed patient medical records reviewed for patients in restraint/seclusion.<br><br>Findings:<br><br>1. Review of policy titled, Restraint Inpatient Unit - Procedure, revised/reapproved 4/13/15, indicated on pg. 3 under physician's order section, after each episode of restraint/seclusion the licensed physician/independent practitioner revises the client's treatment plan of care.<br><br>2. Review of closed patient medical records confirmed patient:<br>A. N1 was placed in 4-way leather restraints on 7/15/15 at 1000 hours. The Initial Treatment Plan was dated 7/10/15 and was not updated until 7/17/15.<br>B. N3 was placed in 4-way leather restraints on | A 166 | | |

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| A 166 | Continued From page 7<br>11/18/15 at 0430 hours. The Initial Treatment Plan was dated 11/13/15 and was not updated until 11/20/15.<br>C. N4 was placed in 4-way leather restraints on 9/2/15 at 0520 hours. The Initial Treatment Plan was dated 8/31/15 and was not updated after the restraint/seclusion.<br>D. N5 was placed in 4-way leather restraints on 8/18/15 at 1625 hours. The Initial Treatment Plan was dated 8/18/15 and was not updated until 8/25/15.<br><br>3. In interview on 12/7/15 at approximately 1410 hours, staff #21 (Supervisor of Medical Records) confirmed the client's treatment plan of care for patients N1, N3, N4 and N5 lacked revision after restraint/seclusion as required by facility policy and procedure. | A 166 | | |
| A 168 | 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to ensure the use of restraint/seclusion was in accordance with facility policy and procedure for 4 of 4 (N1, N3, N4 and N5) closed patient medical records reviewed for patients in restraint/seclusion.<br><br>Findings: | A 168 | | |

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| A 168 | Continued From page 8<br><br>1. Review of policy titled, Restraint Inpatient Unit - Procedure, revised/reapproved 4/13/15, indicated on:<br>A. pg. 3 under physician's order section, each order for restraint/seclusion must include the date and beginning and ending time.<br>B. pg. 4 under debriefing section, debriefing is to occur with staff, the client, the client's family (if appropriate) as soon as possible after the incident but not longer than 24 hours after the episode.<br>C. pg. 5 under documentation section, each episode of restraint should include whether or not any injuries were sustained from the episode.<br><br>2. Review of policy titled, General Inpatient Charting Rules - Procedure, revised/reapproved 8/25/15, indicated all notations in the patient medical record must be signed, dated and timed and all physician orders must be signed by the physician.<br><br>3. Review of closed patient medical records confirmed patient:<br>A. N1 was placed in 4-way leather restraints on 7/15/15 at 1000 hours. The Initial Order on pg. 5 of the Restraint/Seclusion Flow Sheet lacked an ending time. The section on Injuries/Death sustained was blank. The time of debriefing was indicated as 1330 hours, but the restraint ended at 1335 hours.<br>B. N3 was placed in 4-way leather restraints on 11/18/15 at 0430 hours. The Initial Order on pg. 5 of the Restraint/Seclusion Flow Sheet lacked an ending time and physician signature. The section on Injuries/Death sustained was blank. The time of debriefing was indicated as 1045 hours, but the restraint ended at 1100 hours. | A 168 | | |

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| A 168 | Continued From page 9<br>C. N4 was placed in 4-way leather restraints on 9/2/15 at 0520 hours. The Initial Order on pg. 5 of the Restraint/Seclusion Flow Sheet lacked an ending time, physician signature and time of order. The section on Injuries/Death sustained was blank. The time of debriefing was indicated as 1420 hours, which was the ending time of the restraint.<br>D. N5 was placed in 4-way leather restraints on 8/18/15 at 1625 hours. The Initial Order on pg. 5 of the Restraint/Seclusion Flow Sheet lacked a physician signature, date, and time. The section on Injuries/Death sustained was blank. The time of debriefing was indicated as 1915 hours, which was the ending time of the restraint.<br><br>4. In interview, on 12/7/15 at approximately 1410 hours, staff #21 (Supervisor of Medical Records) confirmed the above-mentioned patient medical records lacked documentation of either an ending time; physician signature, date, and time; or time of order on the Initial Order of the Restraint/Seclusion Flow Sheet and injuries were not addressed and debriefing did not occur after the restraint as required by facility policy and procedure. | A 168 | | |
| A 206 | 482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT OR SECLUSION<br><br>[The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:]<br><br>(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. | A 206 | | |

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| A 206 | Continued From page 10<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to ensure staff certification in the use of cardiopulmonary resuscitation (CPR) for 1 of 6 (#18) mental health tech personnel files reviewed.<br><br>Findings:<br><br>1. Review of policy titled, Emergency Medical Response Procedure, revised/reapproved 4/16/2015, indicated designated staff receives training in First Aid/CPR and are responsible for assessing, monitoring and providing basic first aid until emergency medical staff can arrive.<br><br>2. Review of document titled, Pre-employment and Ongoing Employment Requirements, revised/reapproved 4/15/2015, indicated Mental Health Technicians must have current CPR certification.<br><br>3. Review of mental health tech personnel files on 12/8/15 at approximately 1145 hours, confirmed staff #18 (Mental Health Technician) was hired on 8/24/15 and did not have CPR certification until 11/13/15.<br><br>4. Review of timesheet for staff #18 on 12/9/15 at approximately 1200 hours, confirmed they worked 8/24-28/15, 8/31-9/2/15, 9/5-12/15, 9/14-16/15, 9/19/15, 9/20/15, 9/22-24/15, 9/26-28/15, 9/30/15, 10/3-6/15, 10/9-13/15, 10/15-20/15, 10/23/15, 10/24/15, 10/26/15, 10/29-11/1/15, 11/3-5/15, 11/7-10/15 and 11/12/15.<br><br>5. Review of Root Cause Analysis Meeting Minutes dated 9/30/15, confirmed staff #18 | A 206 | | |

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| A 206 | Continued From page 11<br>performed CPR during a critical incident on 9/28/15 for patient N5 who suffered cardiac arrest.<br><br>6. In interview, on 12/9/15 at approximately 1400 hours, staff #23 (Human Resources Business Partner) and staff #24 (Human Resources Business Partner) confirmed staff #18 lacked CPR certification until 11/13/15 and worked on the days mentioned above. | A 206 | | |
| A 338 | 482.22 MEDICAL STAFF<br><br>The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.<br>This CONDITION is not met as evidenced by:<br>Based on document review and interview, it was determined that medical staff failed to operate under approved medical staff bylaws by the governing board. The facility failed to adopt rules for eligibility for appointment by the governing body (see A 339); failed to provide Medical Staff Periodic Appraisals by its members (see A 340); failed to ensure Medical Staff Credentialing Process (see A 341); failed to adopt bylaws and rules to describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies (see A 350); failed to ensure Medical Staff bylaws (see A 353); failed to ensure the Governing Board has approved the Medical Staff bylaws (see A 354); failed to approve written Medical Staff bylaws that describe the privileging process to be used by the hospital (see A 355); failed to have an Organization of the Medical Staff (see A 356); failed to define the Medical Staff | A 338 | | |

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| A 338 | Continued From page 12<br>Qualifications (see A 357) and failed to have written criteria for Medical Staff privileging (see A 363).<br><br>The cumulative effect of these systematic problems resulted in the hospital's inability to ensure quality medical care. | A 338 | | |
| A 339 | 482.22(a) ELIGIBILITY & PROCESS FOR APPT TO MED STAFF<br><br>The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope of practice laws, the medical staff may also include other categories of physicians (as listed at §482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the medical staff does not have bylaws or rules that determine eligibility for appointment by the governing body of 12 of 12 psychiatrists on the on call medical staff schedule and 5 of 5 Nurse Practitioners.<br><br>Findings include:<br><br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Governing Board failed to ensure the Medical Staff have bylaws to define categories of practitioners that are eligible candidates for appointment to the medical staff. The Medical Staff does not have medical staff bylaws. | A 339 | | |
| A 340 | 482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS | A 340 | | |

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| A 340 | Continued From page 13<br>The medical staff must periodically conduct appraisals of its members.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the Medical Staff failed to conduct periodical review for 12 of 12 psychiatrists on the on call medical staff schedule and 5 of 5 Nurse Practitioners.<br><br>Findings include:<br><br>1. The 12 Medical Staff Practitioners and 5 Nurse Practitioner's performance evaluations were signed and approved by Human Resource Division. The performance evaluations were not periodical reviews by the members of the Medical Staff.<br><br>2. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff are not appointed by the Governing Board. Medical staff members are hired by human resource and the Chief Executive Officer has the hiring authority. | A 340 | | |
| A 341 | 482.22(a)(2) MEDICAL STAFF CREDENTIALING<br><br>The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations, in addition to the requirements contained in this section. | A 341 | | |

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| A 341 | Continued From page 14<br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the Medial Staff failed to examine credentials of medical staff for membership and make recommendations to the governing body on appointment of 12 of 12 psychiatrists on the on call medical staff schedule and 5 of 5 Nurse Practitioners.<br><br>Findings include:<br><br>1. The facility lacked documentation that the Medical Staff to have medical staff bylaws that addressed the categories of practitioners that are eligible for appointment to the medical staff. Therefore, 12 Medical Staff Practitioners and 5 Nurse Practitioners were not recommended to the governing body for appointment.<br><br>2. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Governing Board failed to ensure the Medical Staff have bylaws to define categories of practitioners that are eligible candidates for appointment to the medical staff. The Medical Staff does not have medical staff bylaws. | A 341 | | |
| A 350 | 482.22(b)(4)(ii) SYSTEM MEDICAL STAFF REQUIREMENTS<br><br>[§482.22(b)(4) - If a hospital is part of a hospital system consisting of multiple separately certified hospitals and the system elects to have a unified and integrated medical staff for its member hospitals, after determining that such a decision is in accordance with all applicable State and local laws, each separately certified hospital must demonstrate that:] | A 350 | | |

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| A 350 | Continued From page 15<br><br>(ii) - The unified and integrated medical staff has bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees, and which include a process for the members of the medical staff of each separately certified hospital (that is, all medical staff members who hold specific privileges to practice at that hospital) to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their hospital;<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the medical staff failed to adopt bylaws and rules to describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies.<br><br>Findings include:<br><br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Governing Board failed to ensure the Medical Staff have bylaws and rules and regulations. | A 350 | | |
| A 353 | 482.22(c) MEDICAL STAFF BYLAWS<br><br>The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview, the Medical Staff failed to adopt medical staff bylaws. | A 353 | | |

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| A 353 | Continued From page 16<br><br>Findings include:<br><br>In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff does not have bylaws and rules. | A 353 | | |
| A 354 | 482.22(c)(1) APPROVAL OF MEDICAL STAFF BYLAWS<br><br>[The bylaws must:]<br><br>(1) Be approved by the governing body.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the Governing Body failed to approve medical staff bylaws.<br><br>Findings include:<br><br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated Medical Staff do not have bylaws for the Governing Body to approve. | A 354 | | |
| A 355 | 482.22(c)(2) MEDICAL STAFF PRIVILEGING<br><br>[The bylaws must:]<br><br>(2) Include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.)<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the Medical Staff bylaws failed to include a statement of the duties and privileges of each category of medical staff.<br><br>Findings include: | A 355 | | |

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| A 355 | Continued From page 17<br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff does not have bylaws and rules. | A 355 | | |
| A 356 | 482.22(c)(3) ORGANIZATION OF MEDICAL STAFF<br><br>[The bylaws must:]<br><br>(3) Describe the organization of the medical staff.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the Medical Staff failed to ensure bylaws that describe the organization of the Medical Staff.<br><br>Findings include:<br><br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff does not have bylaws and rules. | A 356 | | |
| A 357 | 482.22(c)(4) MEDICAL STAFF QUALIFICATIONS<br><br>[The bylaws must:]<br><br>(4) Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the Medical Staff failed to have Medical Staff bylaws that describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.<br><br>Findings include: | A 357 | | |

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| A 357 | Continued From page 18<br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff does not have bylaws and rules. | A 357 | | |
| A 363 | 482.22(c)(6) CRITERIA FOR MEDICAL STAFF PRIVILEGING<br><br>[The bylaws must:]<br><br>Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4).<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the Medical Staff failed to have Medical Staff bylaws that include the criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.<br><br>Findings included:<br><br>1. In interview at 3:05 PM on 12/7/2015, staff member #AD5 (Chief Executive Officer) indicated the Medical Staff does not have bylaws and rules. | A 363 | | |
| A 622 | 482.28(a)(3) COMPETENT DIETARY STAFF<br><br>There must be administrative and technical | A 622 | | |

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| A 622 | Continued From page 19<br>personnel competent in their respective duties.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to ensure two (2) of three (3) staff members (#L14 and #L15) met minimum hiring requirements in accordance with facility policy and procedure<br><br>Findings include:<br><br>1. Review of a document titled "Position Description/Performance Appraisal/Competency Assessment" indicated a high school diploma or equivalent was a minimum hiring requirement for the position of "Dietary Technician".<br><br>2. There was no documentation of a high school diploma or equivalent in the personnel records of Staff Members #L14 and #L15, dietary technicians.<br><br>3. On 12-8-2015 at 11:08 AM, Staff Members #L9, Human Resources Business Partner, and #L10, Human Resources Business Partner, acknowledged there was no documentation of a high school diploma or equivalent for Staff Members #L14 and #L15. | A 622 | | |
| A 630 | 482.28(b)(2) DIETS<br><br>All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals.<br>This STANDARD is not met as evidenced by: | A 630 | | |

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| A 630 | Continued From page 20 | A 630 | | |

Based on document review and interview, the facility failed to provide the appropriate diet for 1 of 1 (N6) closed patient medical records reviewed related to diet.

Findings:

1. Review of Indiana Dietary Manual, revised/reapproved 1/2015, indicated on pg. 305 for a Mechanical or Dental Soft Diet that foods not allowed include: dry, tough or crusty bread; and foods allowed include: easy to chew breads, toast, crackers, graham crackers.

2. Review of closed patient medical records on 12/8/15 at approximately 1630 hours, confirmed per:
A. Diet History/Nutrition Assessment dated 3/2/15, patient's (N6) diet changed to soft and patient has no teeth but does have dentures.
B. Progress Notes dated 3/15/15, nurse was called to aid patient (N6) and informed by tech patient was observed choking. Heimlich procedure was initiated and patient brought up some crumbs and mucus.

3. Review of Root Cause Analysis regarding event that occurred 3/15/15 at 0730 hours, confirmed patient choked on a biscuit and suffered cardiac arrest.

4. In interview, on 12/8/15 at approximately 1532 hours, staff #27 (Dietitian, Food Service Supervisor) confirmed biscuits are softened by patient's mouth saliva. Agree that biscuit falls under foods not allowed under Mechanical or Dental Soft Diet in the Indiana Dietary Manual on pg. 305.

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| A 630 | Continued From page 21<br>5. In interview, on 12/8/15 at approximately 1532 hours, staff #20 (Vice President of Mental Health Services) confirmed the facility is lacking a policy related to the frequency of patient assessment by dietary staff and documentation of progress notes. The last dietary progress note for patient N6 was dated 3/12/15. | A 630 | | |
| A 700 | 482.41 PHYSICAL ENVIRONMENT<br><br>The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.<br><br>This CONDITION is not met as evidenced by:<br>Based on Life Safety Code (LSC) survey, Regional Mental Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.<br><br>This two story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and patient sleeping rooms. The In-Patient Unit was located on the second floor and has a capacity of 16. The census was 15 at the time of this survey.<br><br>Based on LSC survey and deficiencies found (see CMS 2567L), it was determined that the facility failed to ensure 1 of 1 "Regional Mental Health Center" fire barriers to a nonconforming | A 700 | | |

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| A 700 | Continued From page 22 | A 700 | | |

occupancy was protected by a two hour fire rating (see K 011), failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier wall was protected to maintain the smoke resistance of each smoke barrier (see K 025), failed to ensure the corridor door to 1 of 1 soiled linen storage room, a hazardous area, was provided with self closer and would latch into the frame (see K 029), failed to ensure exit access was arranged so 1 of 3 exits was readily accessible at all times (see K 038), failed to conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters (see K 050), failed to ensure 32 of 32 smoke detectors were maintained regarding detector sensitivity requirements (see K 052), failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years and failed to replace 4 of 6 bathroom corroded sprinkler heads in 6 bathrooms and 2 of 2 painted recessed sprinkler head covers in room E206 (see K 062), failed to ensure 1 of 1 generator was in accordance with the standard for emergency and standby power systems and failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test (see K 144), failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition (see K 147), failed to maintain the condition of the hospital environment in order to assure the safety and well-being of patients for 1 of 1 (Inpatient Unit) toured (see A 0701) and one of three rooms in the kitchen failed to be maintained to ensure employee safety (see A 0724).

The cumulative effect of these systemic problems resulted in the hospital's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure

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| A 700 | Continued From page 23<br>the provision of quality health care in a safe environment. | A 700 | | |
| A 701 | 482.41(a) MAINTENANCE OF PHYSICAL PLANT<br><br>The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to maintain the condition of the hospital environment in order to assure the safety and well-being of patients for 1 of 1 (Inpatient Unit) toured.<br><br>Findings:<br><br>1. Review of policy titled, Soothing Room Procedure, revised/reapproved 4/27/15, confirmed clients may use the soothing room during non-programming times and the nurse can offer prescribed anxiety and agitation medication to help with relaxation.<br><br>2. While on tour of the Inpatient Unit on 12/9/15 at approximately 1115 hours, accompanied by staff #20 (Vice President of Mental Health Services), the following was observed in the soothing room:<br>A. a cord (approximately 4-6 feet long) attached to the back of the television and plugged into a wall outlet;<br>B. a cord (approximately 3-4 feet long) attached to the back of a music system and plugged into a wall outlet.<br>C. a patient stretcher/gurney with 4-point | A 701 | | |

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| A 701 | Continued From page 24<br>leather restraint straps attached to it.<br><br>3. In interview, on 12/9/15 at approximately 1215 hours, staff #7 (Director of Nursing) confirmed there are cords to electronic devices in the soothing room that may present a hazard to patients using the room. The patient stretcher/gurney with 4-point leather restraint straps is stored in the soothing room because there is no other place to store it. | A 701 | | |
| A 709 | 482.41(b) LIFE SAFETY FROM FIRE<br><br>Life Safety from Fire<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure 1 of 1 "Regional Mental Health Center" fire barriers to a nonconforming occupancy was protected by a two hour fire rating, failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier wall was protected to maintain the smoke resistance of each smoke barrier, failed to ensure the corridor door to 1 of 1 soiled linen storage room, a hazardous area, was provided with self closer and would latch into the frame, failed to ensure exit access was arranged so 1 of 3 exits was readily accessible at all times, failed to conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters, failed to ensure 32 of 32 smoke detectors were maintained regarding detector sensitivity requirements, failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years and failed to replace 4 of 6 bathroom corroded sprinkler heads in 6 bathrooms and 2 of 2 painted recessed sprinkler head covers in room E206, failed to ensure 1 of 1 | A 709 | | |

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generator was in accordance with the standard for emergency and standby power systems and failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test, failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition, failed to maintain the condition of the hospital environment in order to assure the safety and well-being of patients for 1 of 1 (Inpatient Unit) toured (see A 0701) and one of three rooms in the kitchen failed to be maintained to ensure employee safety (see A 0724).

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Findings:

1. Observation with S1, Supervisor of General Services, on 12/8/15 at 12:24 p.m. noted the wall which separates the "Regional Mental Health Center" on the second floor and the business offices on the second floor, a nonconforming occupancy, did not have any rating tags on either exit doors which open to the business offices.

2. In interview at the time of observation, the Supervisor of General Services acknowledged the doors did not indicate an hourly rating tag and confirmed no cite plans were available for review for the construction of the walls.

3. Observations with the Supervisor of General Services on 12/8/15 at 12:34 p.m. noted the smoke barrier wall near the West Exit had two unsealed penetrations. Above the ceiling tile was the unsealed penetration which was a one-eighth of an inch. Also, above the ceiling tiles was an unsealed penetration around sprinkler pipe measuring one-eighth of an inch.

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4. In interview at the time of observation, the Supervisor of General Services acknowledged the aforementioned condition and provided the measurements.

5. Observation with the Supervisor of General Services on 12/8/15 at 12:22 p.m. noted the corridor door to the only soiled linen storage room contained one very large container without a lid. Inside the container was a bag of soiled linen.

6. In interview at the time of observation, the Supervisor of General Services could not provide an estimation of how many gallons the very large container could hold, but confirmed the very large container could store more than 32 gallons and confirmed this room was used for soiled linen storage.

7. Observation with the Supervisor of General Services on 12/8/15 at 11:47 a.m. noted the "Exit To Deck" door had an exit sign above it. Continuing through the discharge, there was a patio which led to a door, which led down a few stairs without a ramp, then to grass to the parking lot.

8. In interview at the time of observation, the Supervisor of General Services acknowledged the aforementioned condition and confirmed that path was considered an exit.

9. Record review, with the Supervisor of General Services, of the fire drill reports titled "Fire Drill Report Form" on 12/8/15 at 10:21 a.m. indicated the documentation for a second shift fire drill for the third and fourth quarter of 2015 and a third shift fire drill for the fourth quarter of 2015 was not available for review.

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10. In interview at the time of record review, the Supervisor of General Services acknowledged the lack of documentation.
11. Record review with the Supervisor of General Services on 12/8/15 at 10:21 a.m. indicated a smoke detector sensitivity test was not available for review.

12. In interview with Supervisor of General Services at the time of record review, it was indicated that no other documentation was available for review.

13. Review of sprinkler system documentation with the Supervisor of General Services on 12/8/15 at 10:20 a.m. indicated none of the quarterly sprinkler system inspection and testing records showed an internal inspection of the sprinkler system pipes had been conducted.

14. In interview at the time of record review, the Supervisor of General Services acknowledged the aforementioned condition.

15. Observation with the Supervisor of General Services on 12/8/15 between 11:55 a.m. and 12:01 p.m. noted four out of six bathrooms had one corroded sprinkler head in each. Also, the Soothing Room E206 contained two recessed sprinkler head covers. Both recessed sprinkler head covers were painted.

16. In interview at the time of observation, the Supervisor of General Services acknowledged the aforementioned conditions.

17. Record review with the Supervisor of General Services on 12/8/15 at 9:42 a.m. indicated the monthly generator forms failed to include the

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generator load percentage.

18. In interview at the time of record review, the Supervisor of General Services acknowledged the aforementioned condition and confirmed that documentation for an annual load bank test was not available for review.

19. Review of the facility's Emergency Generator monthly testing log with the Supervisor of General Services on 12/8/15 at 9:42 a.m. noted the generator log form failed to document the generator cool down time following its load test.

20. During interview at the time of record review, the Supervisor of General Services acknowledged the aforementioned condition and said the generator "runs for 25 minutes with a 5 minute cool down".

21. Observation with the Supervisor of General Services on 12/8/15 at 12:34 p.m. noted there was exposed wiring in a junction box without a cover by the West Exit above the ceiling tile.

22. In interview at the time of observation, the Supervisor of General Services acknowledged the aforementioned condition.

23. Review of policy titled, Soothing Room Procedure, revised/reapproved 4/27/15, confirmed clients may use the soothing room during non-programming times and the nurse can offer prescribed anxiety and agitation medication to help with relaxation.

24. While on tour of the Inpatient Unit on 12/9/15 at approximately 1115 hours, accompanied by staff #20 (Vice President of Mental Health

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Services), the following was observed in the soothing room:
A. a cord (approximately 4-6 feet long) attached to the back of the television and plugged into a wall outlet;
B. a cord (approximately 3-4 feet long) attached to the back of a music system and plugged into a wall outlet.
C. a patient stretcher/gurney with 4-point leather restraint straps attached to it.

25. In interview, on 12/9/15 at approximately 1215 hours, staff #7 (Director of Nursing) confirmed there are cords to electronic devices in the soothing room that may present a hazard to patients using the room. The patient stretcher/gurney with 4-point leather restraint straps is stored in the soothing room because there is no other place to store it.

26. Review of Material Safety Data Sheets (MSDS) indicated the following:
a. An MSDS for the product "Array Germicidal Bleach and Disinfectant," issued "August 17, 2006" read: "First Aid Measures...Eye Contact...Immediately flush eye with plenty of cool, running water..."
b. An MSDS for the product "Powdered Heavy Duty Plus Dishmachine Detergent," label "Array," revised on "4-21-06" read: "Fist Aid Measures...Eyes: Immediately flush eyes with running water for at least 15-20 minutes..."

27. During kitchen tour on 12-7-2-15 at 2:00 PM, while accompanied by Staff Member #L13, Dietary Manager, the following was observed:
a. A 32 fluid ounce (fl. oz.) squeeze bottle of "Honeywell Eyesaline," lot number "F13007-31", expiration date "11/2015" was mounted to the wall

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| A 709 | Continued From page 30<br>in the dish room. There was no eye wash with running water in the kitchen or dish room.<br>b. A stock bottle of "Array Germicidal Bleach and Disinfectant" on the shelf in the dish room<br>c. A stock bottle of "Array Powdered Heavy Duty Plus Dish Machine Detergent"<br><br>28. On 12-7-2015 at 2:00 PM, Staff Member #L13, Dietary Manager, acknowledged the squeeze bottle eyewash was expired and there was no other eyewash in the kitchen or dish room. | A 709 | | |
| A 724 | 482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE<br><br>Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.<br>This STANDARD is not met as evidenced by:<br>Based on document review, observation and staff interview, one of three rooms in the kitchen failed to be maintained to ensure employee safety.<br><br>Findings include:<br><br>1. Review of Material Safety Data Sheets (MSDS) indicated the following:<br>a. An MSDS for the product "Array Germicidal Bleach and Disinfectant," issued "August 17, 2006" read: "First Aid Measures...Eye Contact...Immediately flush eye with plenty of cool, running water..."<br>b. An MSDS for the product "Powdered Heavy Duty Plus Dishmachine Detergent," label "Array," revised on "4-21-06" read: "Fist Aid Measures...Eyes: Immediately flush eyes with running water for at least 15-20 minutes..." | A 724 | | |

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| A 724 | Continued From page 31<br><br>2. During kitchen tour on 12-7-2-15 at 2:00 PM, while accompanied by Staff Member #L13, Dietary Manager, the following was observed:<br>a. A 32 fluid ounce (fl. oz.) squeeze bottle of "Honeywell Eyesaline," lot number "F13007-31", expiration date "11/2015" was mounted to the wall in the dish room. There was no eye wash with running water in the kitchen or dish room.<br>b. A stock bottle of "Array Germicidal Bleach and Disinfectant" on the shelf in the dish room<br>c. A stock bottle of "Array Powdered Heavy Duty Plus Dish Machine Detergent"<br><br>3. On 12-7-2015 at 2:00 PM, Staff Member #L13, Dietary Manager, acknowledged the squeeze bottle eyewash was expired and there was no other eyewash in the kitchen or dish room. | A 724 | | |
| A 748 | 482.42(a) INFECTION CONTROL OFFICER(S)<br><br>A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the infection control officer failed to implement policies related to control of infections and communicable diseases for 15 of 19 (#1-6, 8, 10-12, 14, 15, and 17-19) personnel files reviewed.<br><br>Findings:<br><br>1. Review of policy titled, Hiring/Employee Relations - Supervisors Instructions, | A 748 | | |

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revised/reapproved 4/17/15, indicated designated staff must have documentation of MMR (measles, mumps, rubella) immunity, Varicella immunity, Hepatitis B immunity and TB (tuberculosis) test.

2. Review of policy titled, Infection Control - Measles, Mumps, Rubella, and Varicella Vaccine Procedures, revised/reapproved 12/16/13, indicated immunity to MMR and Varicella is mandatory for identified staff.

3. Review of policy titled, Infection Control - Employee Tuberculosis Screening Procedure, revised/reapproved 10/15/13, indicated employees listed on the Pre-employment and Ongoing Employment Requirements Chart will be screened for TB at the time of employment and annually.

4. Review of document titled, Pre-employment and Ongoing Employment Requirements, revised/reapproved 4/15/2015, indicated Registered Nurses (RNs) and Mental Health Technicians (MHTs) are identified staff who must have documentation of immunity to MMR and Varicella and annual evidence of TB testing.

5. Review of personnel files on 12/8/15 at 1145 hours and 12/9/15 at 1400 hours, confirmed staff #1-5, 8, 10, and 12 are RNs and staff #14, 15, and 17-19 are MHTs. Staff #:
A. 1-5, 8, 10, 12, 14, 15, and 17-19 were lacking documentation of immunity to Varicella;
B. 10, 14, and 19 were lacking documentation of MMR;
C. 1-3, 5, 6, 8, 10-12, 14, and 19 were lacking documentation of annual TB testing. The last TB test date was 9/14, 7/14, 6/14, 6/14, 11/14, 3/14,

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| A 748 | Continued From page 33<br>6/09, 6/14, 6/14, none, and 6/09, respectively.<br>D. 14 lacked documentation of immunity to Hepatitis B and had a letter dated 4/14/15 in their file requesting them to schedule their first injection of the Hepatitis B vaccination.<br>E. 1-6, 8, 10-12, 14, 15, and 17-19 lacking documentation of Tdap vaccination.<br><br>6. In interview on 12/8/15 at approximately 1300 hours, staff #1 (Infection Control Officer) confirmed RNs and MHTs are designated staff who must have documentation of MMR, Varicella, and Hepatitis B immunity; and evidence of annual TB testing according to facility policy and procedure. All staff mentioned above are also lacking documentation of Tdap vaccination and there is no policy and procedure related to Tdap. | A 748 | | |
| A 749 | 482.42(a)(1) INFECTION CONTROL PROGRAM<br><br>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review, observation and staff interview, the infection control officer failed to: 1) require two of two dietary technicians reviewed to meet employee illness reporting requirements in the Indiana Food Code; 2) ensure dietary personnel followed proper hand washing procedures for one of one dietary technicians observed; 3) ensure the correct strength of the sanitizer used for food contact surfaces for one of one sanitizer buckets observed and 4) failed to develop a system for | A 749 | | |

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| A 749 | Continued From page 34<br>controlling infections and communicable diseases for 1 of 1 (Inpatient Unit) toured.<br><br>Findings include:<br><br>1. Review of the Indiana Food Code at 410 IAC 7-24-120 reads:<br>"The owner or operator of a retail food establishment shall require food employee applicants to whom a conditional offer of employment is made and food employees to report to the person-in-charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or applicant shall report the information in a manner that allows the person-in-charge to prevent the likelihood of foodborne disease transmission, including the date of onset of jaundice or of an illness specified under subdivision (3), if the food employee or applicant:<br>(1) is diagnosed with an illness due to:<br>(A) Salmonella spp.;<br>(B) Shigella spp.;<br>(C) Shiga toxin-producing Escherichia coli;<br>(D) hepatitis A virus; or<br>(E) Norovirus; or<br>(2) has a symptom caused by illness, infection, or other source that is:<br>(A) associated with an acute gastrointestinal illness, such as:<br>(i) diarrhea;<br>(ii) fever;<br>(iii) vomiting;<br>(iv) jaundice; or<br>(v) sore throat with fever; or<br>(B) a lesion containing pus, such as a boil or infected wound that is open or draining and is on:<br>(i) the hands or wrists unless an impermeable | A 749 | | |

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cover, such as a finger cot or stall, protects the lesion and a single use
glove is worn over the impermeable cover;
(ii) exposed portions of the arms unless the lesion is protected by an impermeable cover; or
(iii) other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage;
(3) had a past illness from an infectious agent specified under subdivision (1); or
(4) meets one (1) or more of the following high-risk conditions, such as:
(A) Being suspected of causing, or being exposed to, a confirmed disease outbreak caused by Salmonella spp., Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or norovirus because the food employee or applicant:
(i) prepared food implicated in the outbreak;
(ii) consumed food implicated in the outbreak; or
(iii) consumed food at the event prepared by a person who is infected or ill with the infectious agent that caused
the outbreak or who is suspected of being a shedder of the infectious agent.
(B) Living in the same household as a person who is diagnosed with a disease caused by Salmonella spp., Shigella spp., Shiga toxin-producing Escherichia coli, hepatitis A virus, or norovirus.
(b) For purposes of this section, a violation of subsection (a) is a critical item."

2. Review of policy and procedures indicated the follow policies/procedures did not require dietary technicians to follow the employee illness reporting requirements in 410 IAC 7-24-210:

1. "Infection Control-Reporting Illnesses and Infections Procedure," approved "09/04/2013"

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2. "Infection Control/Work Restrictions Procedure," approved "10/09/2013"

3. In interview on 12-8-2015 at 12:13 PM, Staff Member #L6, Director of Accreditation/Quality Improvement, acknowledged the facility's employee illness policies did not meet the Indiana Food Code at 410 IAC7-24-120.

4. Review of policy/procedure titled: :Dietary Services Sanitation Procedure," approved "08/06/2012" read: "Hands should be washed in hot water...for a minimum of 20 seconds..."

5. On 12-2-2015 at 2:00 PM, Staff Member #L16, Dietary Technician, was observed performing hand washing procedures. The staff member wet their hands, placed one pump of soap on their hands, rubbed their hands together for five seconds, rinsed their hands, placed another pump of soap on their hands, rubbed their hands together again for five seconds, then rinsed their hands with water and dried them with a paper towel.

6. In interview on 12-7-2015 at 3:15 PM, Staff Member #L13, Dietary Manager, acknowledged Staff Member #L16 did not follow proper hand washing procedures.

7. Review of a policy/procedure titled: "Kitchen/Food Preparation/Kitchen Equipment Sanitation Procedure," approved "10/13/2014," indicated a bleach solution with a concentration of 200 parts per million (ppm) was used to sanitize the food preparation area.

8. Manufacturer's instructions on the bottle of the "Array Germicidal Bleach and Disinfectant,"

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indicated a concentration of 200 ppm was required to sanitize nonporous food contact surfaces.

9. During kitchen tour on 12-7-2015 at 2:00 PM, while accompanied by Staff Member #L13, the concentration of the bleach sanitizer solution was tested to be 10 ppm.

10. In interview on 12-7-2015 at 2:00 PM, Staff Member #L13 acknowledged the bleach sanitizer was not 200 ppm, as required by the manufacturer and approved policy/procedure.

11. Review of policy titled, Housekeeping Services, Inpatient Unit - Procedure, revised/reapproved 8/3/15, confirmed universal precautions will be observed by housekeeping staff and routine disinfection protocols will be maintained by the housekeeping department. Also, assigned staff will be responsible for loading filled laundry bags onto the laundry cart, which is stored in the room designated for soiled linen. The used laundry cart will remain in the soiled linen room until removed by maintenance weekly.

12. While on tour of the Inpatient Unit on 12/9/15 at approximately 1115 hours, accompanied by staff #20 (Vice President of Mental Health Services), the following was observed:
A. soiled linen/towels found in patient laundry room and staff #26 (General Services Manager) directed staff to move soiled laundry to soiled utility room;
B. housekeeping staff #25 (Housekeeper) not spraying Virex 256 directly on surfaces, but on paper towels and not leaving on high-touch and bathroom surfaces for 10 minutes. The product was immediately wiped off.

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|---|---|---|---|
| | 154020 | A. BUILDING _____ B. WING _____ | 12/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REGIONAL MENTAL HEALTH CENTER | 8555 TAFT ST MERRILLVILLE, IN 46410 |

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| A 749 | Continued From page 38<br><br>13. Review of Manufacturer's label for Virex 256 confirmed the product is to be left on surfaces for a 10 minute contact time.<br><br>14. In interview on 12/9/15 at approximately 1200 hours, staff #5 (Registered Nurse) confirmed laundry found in patient laundry room was soiled and should have been placed in the soiled utility room, not in the patient laundry room.<br><br>15. In interview on 12/9/15 at approximately 1256 hours, staff #25 (Housekeeper) and staff #26 confirmed Virex 256 was left to stay on surfaces for only 5 minutes. Staff not following manufacturer's label for leaving on for 10 minute contact time. There are also no policies and procedures related to laundry and/or cleaning washing machines or dryers; and no policies and procedures or system that ensures respiratory fit testing is provided at regular intervals to personnel at risk. The facility does not have a respiratory protection program detailing required worksite-specific procedures and elements for required respirator use. | A 749 | | |
| A 884 | 482.45 ORGAN, TISSUE, EYE PROCUREMENT<br><br>Organ, Tissue and Eye Procurement<br><br>This CONDITION is not met as evidenced by:<br>Based on document review and interview, it was determined that the hospital failed have a written agreement with an Organ Procurement Organization and Tissue and Eye Bank Agreements which is effective in carrying out its responsibilities for the conduct of the hospital. The facility failed to have written policies and procedures to address its organ procurement | A 884 | | |

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| A 884 | Continued From page 39<br>responsibilities (see885); The facility failed to have a written agreement with an Organ Procurement Organization (see A886); failed to have a written Tissue and Eye Bank Agreements (see A887); failed to have a designated Requestor (see A889) and failed to educate staff in Organ Procurement (see A891).<br><br>The cumulative effect of these systemic problems resulted in the facility's inability to ensure an effective organ procurement program that is legally responsible for the conduct of the hospital. | A 884 | | |
| A 885 | 482.45(a) WRITTEN POLICIES AND PROCEDURES<br><br>The hospital must have and implement written protocols that:<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the hospital failed to have written policies and procedures on Organ, Tissue, and Eye Procurement.<br><br>Findings include:<br><br>1. In interview at 12:05 PM on 12/7/2015, staff member #AD4 (Vice President Mental Health Services) indicated the hospital does not have written policies and procedures on Organ, Tissue, and Eye Procurement program. | A 885 | | |
| A 886 | 482.45(a)(1) OPO AGREEMENT<br><br>Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines | A 886 | | |

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| A 886 | Continued From page 40<br>medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose;<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the hospital failed to have a written agreement with an Organ Procurement Organization.<br><br>Findings include:<br><br>1. In interview at 12:05 PM on 12/7/2015, staff member #AD4 (Vice President Mental Health Services) indicated the hospital does not have any written agreement with an Organ Procurement Organization. | A 886 | | |
| A 887 | 482.45(a)(2) TISSUE AND EYE BANK AGREEMENTS<br><br>Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the hospital failed to have a written agreement with with a tissue bank and eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues | A 887 | | |

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| A 887 | Continued From page 41<br>and eyes.<br><br>Findings include:<br><br>1. In interview at 12:05 PM on 12/7/2015, staff member #AD4 (Vice President Mental Health Services) indicated the hospital does not have any written agreements with tissue and eye banks. | A 887 | | |
| A 889 | 482.45(a)(3) DESIGNATED REQUESTOR<br><br>The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation.<br><br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the hospital failed to ensure at least one staff member was trained to address methodology for approaching potential donor families.<br><br>Findings include:<br><br>1. Staff personnel training files were reviewed and none of the staff training documentation addresses methodology for approaching potential donor families.<br><br>2. In interview at 12:05 PM on 12/7/2015, staff member #AD4 (Vice President Mental Health Services) indicated no staff member were trained | A 889 | | |

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| A 889 | Continued From page 42<br>in the methodology for approaching potential donor families and requesting organ or tissue donation. | A 889 | | |
| A 891 | 482.45(a)(5) STAFF EDUCATION<br><br>Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues;<br><br>This STANDARD is not met as evidenced by:<br>Based on interview, the hospital failed to work cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues.<br><br>Findings include:<br><br>1. In interview at 12:05 PM on 12/7/2015, staff member #AD4 (Vice President Mental Health Services) indicated the hospital does not have written agreement with an Organ Procurement Organization to address its organ procurement responsibilities; therefore, staff are not trained on organ procurement. | A 891 | | |